

State of Washington  
Department of Retirement Systems  
**ENROLLMENT FORM**

PO Box 48380  
Olympia, WA 98504-8380  
Toll-free: (800) 547-6657  
Olympia area: (360) 664-7000

**INSTRUCTIONS:** Complete this form if you have never been a member of this retirement system, or if you are returning to the LEOFF Retirement System. If you are enrolling in TRS Plan 3, you must complete a Plan 3 Transfer and Rate Selection form in addition to this form. Members in all plans must complete a Beneficiary Designation Form.

**Section 1: Personal Data - To Be Completed by Member**

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SOCIAL SECURITY NUMBER (See back of form)					GENDER (Check one)																								
<div></div>																													
LAST NAME																													
<div></div>																													
FIRST NAME																													
<div></div>															<div></div>														
MIDDLE NAME															MAIDEN NAME														
<div></div>																													
MAILING ADDRESS																													
<div></div>															<div></div>		<div></div>					<div></div>							
CITY															STATE		ZIP CODE					(+4 OPTIONAL )							
<div>M M D D Y Y Y Y</div>								<div></div>										<div></div>											
DATE OF BIRTH								HOME PHONE NUMBER										WORK PHONE NUMBER											

I hereby certify that all of the information I have entered on this form is true and complete.

SIGNATURE OF EMPLOYEE

DATE

**Section 2: To Be Completed by Employer**

<div></div>	<div>M M D D Y Y Y Y</div>	<div><div></div> Public Employees</div>	<div><div></div> State Patrol</div>	<div><div></div> Plan 1</div>	<div><div></div> Elected Official</div>
REPORTING GROUP	FIRST DATE OF EMPLOYEE ELIGIBILITY	<div><div></div> Teachers</div>		<div><div></div> Plan 2</div>	<div><div></div> Gov-Appointed Official</div>
		<div><div></div> Law Enforcement and Fire Fighters</div>		<div><div></div> Plan 3</div>	<div><div></div> City Manager or Administrator</div>
		RETIREMENT SYSTEM - check one		PLAN	SPECIAL EMPL. TYPE

EMPLOYEE POSITION TITLE

PRINT OR TYPE EMPLOYER NAME AND MAILING ADDRESS BELOW

I HEREBY CERTIFY THAT ALL OF THE INFORMATION ENTERED ON THIS FORM IS TRUE AND COMPLETE AND THAT THE EMPLOYEE'S SOCIAL SECURITY NUMBER HAS BEEN VERIFIED.

Print Name

Title of Personnel or Payroll Representative

Signature

( )

Phone Number

This form requests that you provide your Social Security number. 5 U.S.C. Section 552(A) requires that the Department make the following disclosure when requesting that information:

- 26 U.S.C. Sections 6047(D), 6041(A), and 6109(A)(3) authorize DRS to solicit your Social Security number.
- DRS uses your Social Security number to ensure that any amounts disbursed under your account are properly reported to the Internal Revenue Service and as a reference number for tracking all data with regard to your retirement account.
- Routinely, DRS uses the Social Security number as the identifying number for the member file.
- If you do not provide your Social Security number, DRS cannot guarantee that the information you are providing on this form will be properly matched with your member records. This is a particular risk if your name is a fairly common one. Failure to provide your Social Security number may also result in misreporting to the Internal Revenue Service of any disbursements you receive, which may result in adverse tax consequences for you.
- Because DRS uses your Social Security number in order to report disbursements to the IRS as required under federal law, the disclosure of your Social Security number is mandatory.